OPA Complaint Data Report Background and Methodology for Measurement Year 2018

OPA Complaint Data Report Background

The Office of the Patient Advocate (OPA) is statutorily charged under the California Health and Safety Code §136000 with the development and implementation of a multi-departmental complaint data reporting initiative. OPA is mandated to annually report health care complaint data and related consumer assistance information from four state entities with consumer assistance service centers – the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California (collectively called "reporting entities"). These four state reporting entities are statutorily required to submit non-aggregated complaint data to OPA.

The reporting requirements for OPA's annual Complaint Data Report were first established in 2011 through legislation authored by Assemblymember Bill Monning (AB 922, Chapter 552, Statutes of 2011) and amended through a budget trailer bill (SB 857, Chapter 31, Statutes of 2014). This legislation established the state's first multi-departmental health care complaint report. The Complaint Data Report for MY 2018 is expected to be the final annual report due to pending legislation (2020 budget trailer bill) that includes the integration of OPA into a new Center for Data Insights and Innovation and other changes to OPA's statutory requirements.

When OPA began the complaint data reporting initiative, there was an absence of standardized complaint definitions and coding across the state reporting entities. OPA has worked closely with the reporting entities to address differences and make ongoing improvements toward collecting and reporting comparable data. After rounds of testing and fine-tuning of collection tools, the reporting entities provided their first complaint data submissions to OPA in March 2015 containing records of complaints closed in 2014. The first Complaint Data Report, the *Baseline Report to the Legislature for Measurement Year 2014*, was issued in May 2016. Over 100,000 complaint records were submitted for the baseline year. In the subsequent rounds of Measurement Year (MY) data submissions, OPA continued to adjust the coding to allow for the unique types of complaints and processes used by the reporting entities. OPA released the Annual Complaint Data Reports for MY 2015 in January 2017, for MY 2016 in April 2018, and for MY 2017 in March 2019.

Enhancements and Changes for the Measurement Year 2018 Report

- DMHC's data collection update allowed for cases with multiple reasons to have multiple results be directly tied to each reason, which enhanced reason-to-result analysis. DMHC submitted duplicate results for the first time due to the reporting change. OPA updated its analysis methodology to account for the duplicate case results when comparing to prior year data.
- DHCS resumed reporting in MY 2018 for demographic categories that had not been reported in its MY 2017 Managed Care data (Race, Ethnicity, and Primary Language).
- DHCS requested that the service center previously reported as the Medi-Cal Dental Program Beneficiary Customer Service Center be referred to as the Medi-Cal Dental Telephone Service Center.

Measurement Year 2018 Data Sources

This fourth OPA Annual Complaint Data Report evaluates health care complaints closed during MY 2018 (January 1 through December 31, 2018), and provides comparisons with MYs 2016 and 2017 when possible. DMHC, DHCS, CDI, and Covered California are statutorily required to annually provide OPA with non-aggregated complaint data and other consumer assistance information. The 2018 complaint records submitted to OPA by reporting entity:

DMHC

Complaint Types: Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse

Data Source: The DMHC complaint data and supplemental survey submissions were provided by the department's Help Center.

DHCS

Complaint Type: State Fair Hearings [conducted by the California Department of Social Services (CDSS)]

Data Sources: The DHCS Information Management Division coordinated the department's complaint data and supplemental survey submissions. The complaint data was sourced from various DHCS divisions that maintain records about State Fair Hearings conducted by the CDSS State Fair Hearings Division involving the DHCS divisions' programs. The following DHCS divisions contributed data for MY 2018: Benefits, California Medicaid Management Information System, Clinical Assurance and Administrative Support, Long Term Care, Managed Care Operations, Medi-Cal Dental Services, and Mental Health Services.

CDI

Complaint Types: Standard Complaints and Independent Medical Reviews

Data Source: The CDI complaint data and supplemental survey submissions were provided by the department's Consumer Services Division.

Covered California

Complaint Types: State Fair Hearings (conducted by CDSS) and State Fair Hearings: Informal Resolution (referred by CDSS for resolution by Covered California without a hearing)

Data Sources: The Covered California Policy Division coordinated the complaint data and supplemental survey submissions. The complaint data submission included information from the CDSS State Fair Hearings Division about State Fair Hearings, including both hearings decided by an Administrative Law Judge and hearing requests referred back to Covered California for informal resolution. The supplemental survey data was from the Covered California Service Center Division.

Data Collection Tools

To execute the reporting requirements per the Health and Safety Code §136000, OPA has used three primary tools to collect data from the reporting entities for MYs 2014-2018: 1) Complaint Data Workbook, 2) Complaint Data Validation Application, and 3) Consumer Assistance Supplemental Survey. OPA used these tools to collect comparable data about the service centers operated by CDI, DMHC, DHCS, and Covered California and about the complaints made by health care consumers to these reporting entities' complaint review systems. The complaint data collected is comprised of a combination of qualitative descriptive information as well as the quantitative records on the actual complaints closed during the measurement year.

Based on feedback from the reporting entities on ways to improve the efficiency of the reporting process, OPA moved to an annual submission process for MY 2017 and later. OPA continued to collect other service center information through the Consumer Assistance Supplemental Survey tool. The 2014-2016 complaint data was previously obtained through a biannual submission process, with separate submissions of Quarters 1 -2 data and Quarters 3-4 data at different times during the year.

Complaint Data Validation Application and Workbook

The four reporting entities submitted MY 2018 complaint data to OPA using a web-based Complaint Data Validation Application. This application validates data based on the data categories and elements established

for each measurement year collection. Complaint data submissions must meet an established error rate threshold in order to be accepted through validation. Accepted MY 2018 files had an error rate below one percent.

In partnership with its information technology team, OPA transitioned to this web-based collection tool for MY 2015 data submissions to improve the efficiency and accuracy of the data collection process. For MY 2014, the Complaint Data Workbook served as the primary data collection tool to create the cumulative database of complaint cases submitted by CDI, DHMC, DHCS, and Covered California. After the transition to the web-based application, the Workbook spreadsheet served as a reference document of acceptable data elements.

Most of the complaint data collection categories and elements are based on standard complaint codes used by the National Association of Insurance Commissioners (NAIC). Through collaborative efforts to work with the reporting entities and stakeholders, OPA has adjusted data elements each year to meet reporting objectives and align with the state reporting entities' systems. A Glossary of Complaint Data Report terms is included in Appendix A of each Annual Complaint Data Report to the Legislature. The MY 2018 Report Glossary is posted on the OPA website at www.opa.ca.gov/ComplaintsReports/Documents/ComplaintReport2018_Glossary.pdf.

Consumer Assistance Supplemental Survey

Through an annual Consumer Assistance Supplemental Survey, the reporting entities provide to OPA additional information about their consumer assistance service centers. This survey information includes consumer call statistics and other service center contact volumes, enrollment figures for plans and programs the entities oversee, and descriptive information about their service centers, such as basic operations (phone numbers, website, hours, etc.), complaint protocols and referral procedures, and system capabilities (communication and database) for tracking calls and complaints.

Data Quality Assurance

Complaint data submissions for MY 2018 from the reporting entities met an error rate threshold of one-percent in order to be accepted through the web-based validation application. This collection tool validated data submissions based on established data categories and elements and acceptable standardized formats. OPA and its public reporting contractor, the National Committee for Quality Assurance (NCQA), conducted additional quality assurance reviews to validate the complaint submissions while preparing the data for analysis. Reporting entities provided guidance or resubmitted data corrections as needed to address any issues noted through the validation and quality assurance activities. OPA's report analysis was further reviewed by NCQA and the reporting entities prior to publication.

Requests for Assistance and Inquiry Methodology

Requests for assistance volumes represent the full volume of consumer assistance reported to OPA for each entity, encompassing both complaints and inquiries. OPA calculates requests for assistance and inquiry volumes depending on the role of its service center(s) for processing the entity's reported complaints.

For DMHC and CDI, which reported complaint data to OPA about complaints handled directly by their respective service centers:

- The service center volume reported to OPA through the Supplemental Survey is counted as the entity's requests for assistance volume.
- The entity's inquiry volume is calculated by subtracting the volume of complaints reported to OPA from the overall service center volume.

For DHCS and Covered California, which reported complaint data to OPA about State Fair Hearings that are handled by CDSS rather than initiated through their respective service centers:

- The service center volume(s) reported to OPA through the Supplemental Survey is counted as the entity's inquiry volume. DHCS reported inquiry data from multiple service centers, which was totaled for the overall DHCS inquiry volume.
- The entity's requests for assistance volume is calculated by adding the volume of complaints reported to OPA to the service center volume(s).

Health Plan Complaint Ratios

In order to provide a more equitable comparison of health plans of various sizes, OPA calculated health plan complaint ratios by taking the number of closed complaints associated with a health plan and dividing it by the number of enrollees the health plan had in 2018. OPA obtained enrollment figures from the reporting entities for the health plans associated with each entity's jurisdiction.

Changes to enrollment data methodologies continue to be made to better align with reporting entities' usual collection and reporting processes. Due to timing and other reporting methodology differences, enrollment figures may not be comparable from year to year.

- For 2018, like the previous reporting year, DMHC and CDI provided December enrollment data and DHCS and Covered California provided March enrollment data.
- Although the DMHC 2018 enrollment total shown in the report is for full-service health plans only and excludes enrollment in specialty health plans, DMHC still provided specialty plans' enrollment figures for the health plan complaint ratio analysis.

Like the previous year, the CDI MY 2018 health plan ratios were calculated based on complaint totals CDI provided for its health plans that had 25 or more complaints closed during the measurement year. In years prior to MY 2017, OPA determined the plan totals from CDI's submitted complaint dataset. CDI submitted its MY 2017-2018 complaint records without health plans identified.

OPA established an enrollment threshold for health plan-related displays in the public complaint data reports. Health plans displayed have over 70,000 members during the measurement year.

Reason-to-Result Analysis

For MY 2018, OPA analyzed the complaint results for the top three complaint reasons reported by DMHC, DHCS, and Covered California. OPA's data collection fields allow for reporting entities to submit up to three reasons and up to three results for each complaint record.

DMHC's reason-to-result analysis was enhanced for MY 2018 due to a data collection update that allowed DMHC to more directly attribute a result (or results) to each reason for its more complex cases that had multiple reasons reviewed. DMHC recorded up to three results per reason (up to nine per case). The change meant that DMHC was able to distinguish case results that varied between reasons. In the prior years, up to three results were recorded for the complaint case as a whole and all reported results were more generally applied to all reasons.

The reason-to-result analysis also was possible for DHCS's and Covered California's top complaint reasons because DHCS's associated records had a limited number of results combinations and all of Covered California's records had a single complaint reason and a single result.

CDI submitted more complex datasets containing many complaint records with multiple reasons and multiple results, which cannot be separated into a single reason-to-single result breakdown. The complaints with multiple reasons and results cannot be omitted from the analysis without skewing the findings.

County Complaint Ratios

In order to provide a more equitable comparison of counties of various sizes, OPA calculated MY 2018 county complaint ratios for DHCS and Covered California. For each respective health care program, the number of closed complaints associated with a county was divided by the number of the program's 2018 enrollees in the county. The county complaint totals were based on the complainants' identified resident county. OPA obtained program enrollment figures by county from DHCS and Covered California. For public display of the county ratios in the complaint data reports, OPA established a thresholds of at least 10,000 program members and over 10 complaints for the county during the measurement year.

Privacy Considerations

OPA follows California Health and Human Services Agency (CHHS) guidelines to ensure that publicly reported complaint data meets the requirements of the California Information Practices Act and the Health Insurance Portability and Accountability Act. In addition, Data Usage Agreements with DHCS and Covered California include privacy requirements for OPA's handling of those entities' data.

Data is de-identified prior to public reporting according to the "CHHS Data De-Identification Guidelines" document, which is available for download through the online CHHS Data Playbook Resource Library (https://chhsdata.github.io/dataplaybook//resource_library/). Categories with complaint volumes of 10 complaints or fewer are not publicly displayed, unless aggregated into a larger category grouping.

Additional Guidance about the Complaint Data and Resulting Analysis

One of the ongoing challenges for meaningful analysis of health care complaint data across reporting entities is the differences in data collection and complaint systems, which are not standardized in terms of definitions, coding, tracking, or performance metrics. OPA continues to work with all of the reporting entities to improve and standardize the reporting of complaint data to OPA.

- Analyses of many data categories remain in separate reporting entity sections rather than aggregated statewide due to complaint system differences. OPA urges caution on comparing these categories across reporting entities or aggregating data into a statewide metric.
- Meaningful comparisons between measurement years may be limited due to annual adjustments made for standardization or alignment improvements.
- Although a pattern or emergence of consumer complaints may indicate systemic issues, complaint data can be an imperfect measure when comparing findings by reporting entity, coverage type, and similar categories.

Appendix A. Complaint Data Collection Categories and Elements for Measurement Year 2018

The reporting entities submitted data to OPA using the following standardized data categories and elements largely based on complaint coding established by the National Association of Insurance Commissioners. In collaboration with the reporting entities, OPA has added and adjusted accepted data elements to better align with data collected by DMHC, DHCS, CDI, and Covered California.

Case ID

Required field. The Case ID must be unique for each reported complaint record.

Type of Complaint

Required field. Accepted elements:

- Complaint/Standard Complaint: STD
- DSS State Fair Hearing
- DSS State Fair Hearing: Informal Resolution
- Independent Medical Review: IMR
- Quick Resolution: QRN
- Urgent Nurse Case: URG

"DSS State Fair Hearing: Informal Resolution" was first reported for MY 2015 by Covered California, but officially added to the collected elements list for MY 2016.

Initial Mode of Contact

Required field. Accepted elements:

- Counter/In-Person
- Email
- Fax
- Mail
- Online
- Other
- Telephone
- Unknown

Date of Birth

Required field. Accepted elements:

- Date in format of mm/dd/yyyy
- Refused
- Unknown

Age

Accepted elements: Any numeric entry accepted for the data submission.

The OPA report includes analysis based on Age for the following age groups:

- Under 18
- 18-34
- 35-54

- 55-64
- 65-74
- 75 and older
- Unknown

For complaint records where the Date of Birth was provided instead of Age, the complainant's age was calculated as of December 31st of the measurement year. Records submitted without either Age or Date of Birth identified were displayed under the "Unknown" element.

Gender

Required field. Accepted elements:

- Female
- Male
- Nonbinary
- Other
- Refused
- Transgender Female
- Transgender Male
- Unknown

"Transgender Male" and "Transgender Female" and "Nonbinary" were added as new elements for MY 2017 collection.

Race

Required field. Accepted elements:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian
- Native Hawaiian or Other Pacific Islander
- Other
- Other Pacific Islander
- Refused
- Unknown
- White

"Native Hawaiian" and "Other Pacific Islander" were added as separate elements in MY 2017, with the combined element remaining as an option for reporting entities that cannot separate. Starting MY 2016, entities reported complaints under "Other" that were reported in prior years under "Multi-racial" (element was retired). Race elements with low volumes of complaints were combined for the report analysis and displayed under the "Other" element.

Ethnicity

Required field. Accepted elements:

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Refused

Primary Language Spoken

Required field. Accepted elements:

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Hmong
- Japanese
- Korean
- Mandarin
- Other
- Other Chinese
- Refused
- Russian
- Spanish
- Tagalog
- Unknown
- Vietnamese

Primary Language elements with low volumes of complaints were combined for the report analysis and displayed under the "Other" element.

Resident County

Required Field. Accepted elements:

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles
- Madera
- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono

- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Riverside
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Sierra
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tehama
- Trinity
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba
- Out of State
- Refused
- Unknown

The OPA report includes analysis by Resident County. For records where a Resident Zip Code was identified instead of a Resident County, OPA referenced a United States Postal Service Zip Code Database to determine the Resident County. Non-California counties were counted under the "Out of State" element. Records without Resident County submitted and with an invalid zip code (ones that did not match a valid zip code within the USPS reference document) were counted as "Unknown".

Resident Zip Code

Required Field. Accepted elements:

- xxxxx or xxxxx-xxxx (numeric five or nine-digit zip code)
- Refused
- Unknown

Insurer or Plan

Although suggested company names were shared with the reporting entities for standardization purposes, any entry was permitted.

Source of Coverage

Required field. Accepted elements:

- 0505 Individual/Commercial
- 0510 Group
- 0517 State Specific (Other)
- 0522 Covered California/Exchange
- 0557 COBRA
- CalPERS
- Medi-Cal
- Medi-Cal/Medicare
- Medicare
- Uninsured
- Unknown

“Uninsured” was first reported by DMHC in MY 2017, but officially added to the collected elements list in MY 2018. Due to a March 2017 data collection change, DMHC re-categorized complaints as Uninsured that were previously identified under the source of coverage the complainant sought or from which the complainant was cancelled. OPA used the new element for DMHC data within the MY 2017 report. Other reporting entities continue to categorize by the coverage the complainant lost or was seeking.

For MY 2016 collection, “Medi-Cal” was added and “Medi-Cal Fee for Service” and Medi-Cal Managed Care” were removed. This update was made to better align with DHCS reporting preferences. DHCS and DMHC first reported Managed Care and Fee for Service designations under Product Type for MY 2015.

Coverage Product Type

Required field for first product type selection. Up to three selections allowed. Accepted elements:

- 0521 Grandfathered
- 0522 Exchange
- 0523 Pharmacy Benefits
- 0524 Catastrophic
- 0526 Bronze
- 0527 Silver
- 0528 Gold
- 0529 Platinum
- 0530 Health Only
- 0531 Small Group
- 0532 Large Group
- 0533 Child Only
- 0534 Multi State
- 0537 Stand Alone Dental
- 0538 Autism/PDD
- 0539 Student Health
- 0540 Long Term Care
- 0541 Home Health Care
- 0542 Short Term Limited Duration Policy
- 0543 Mental Health
- 0545 Dental
- 0547 Limited Benefits
- 0548 Chiropractic
- 0550 Hospital Indemnity

- 0551 Vision
- 0552 HIPAA
- 0554 Pre-existing Condition
- 0555 Cancer/Dread Disease
- 0576 Medicare Prescription Drug
- 0577 Medicare Supplement
- 0556 Self-Funded/ERISA
- 0558 HMO
- 0559 PPO
- 0560 State Specific Other
- 0576 Medicare Prescription Drug
- 0577 Medicare Supplement
- CCS Demonstration Project (MCO)
- Discount
- EPO
- Fee for Service
- HMO with Deductible
- Managed Care
- Medi-Cal Managed Care: San Benito Model
- Medi-Cal Managed Care: Imperial Model
- Medi-Cal Managed Care: COHS Model
- Medi-Cal Managed Care: Two Plan Model
- Medi-Cal Managed Care: GMC Model
- Medi-Cal Coordinated Care (CCI)
- Medi-Cal Managed Care: Rural Model
- POS
- PPO with Deductible
- Uninsured
- Unknown

"0576 Medicare Prescription Drug" and "0577 Medicare Supplement" were added in MY 2018 at the request of CDI to better align with current collection categories. "0535 Medicare Supplement" was removed for MY 2018 and entities were advised to remap data to the newly added "0577 Medicare Supplement" element.

"Discount" and "Uninsured" also were added in MY 2018 to align with DMHC's data collection. DMHC first reported "Uninsured" and "Discount" as product types in MY 2017. Records identified as "Uninsured" were previously reported under the source of coverage the complainant sought or from which the complainant was cancelled. Records identified as "Discount" were previously reported as either "HMO" or "PPO," depending on the Discount plan product. DMHC made related data collection changes starting in March 2017. OPA displayed the new elements for DMHC data within the MY 2017 report. Other reporting entities continue to categorize by the coverage the complainant lost or was seeking.

"0540 Long Term Care" was added as MY 2017 collection element, replacing the DHCS-oriented "Long Term Care: PACE" and "Long-Term Care: SCAN" elements. OPA's MY 2016 report analysis included "Long Term Care" for the first time, aligning with data submitted by DHCS that did not correspond to the PACE and SCAN designations.

"Fee for Service" and "Managed Care" elements were added under Product Type for MY 2016 collection and analysis to align with DHCS reporting preferences for categorizing its delivery systems, and the data reported by DHCS and DMHC for MY 2015. These designations were previously reported under Source of Coverage. "HMO with Deductible" was added for MY 2016 collection to better align with data reported by DMHC.

DHCS reports its delivery systems as product types. Data for its Breast and Cervical Cancer Program is submitted and counted in the statewide analysis as 0555 Cancer/Dread Disease, but appears under the program name within the DHCS report section.

Plan Regulator

Required field. Accepted elements:

- CDI
- CMS
- DMHC
- DOL
- No Regulator
- OPM
- Other
- Out of State DOI
- Unknown

Starting in MY 2017, “No Regulator” was added as a collection element and “CalPERS” was removed.

Complaint Reason

Required field for first complaint reason selection. Up to three selections allowed. Accepted elements:

- 0805 Premium & Rating
- 0807 Dependent Age
- 0809 Waiting Periods
- 0810 Refusal to Insure
- 0815 Cancellation
- 0816 Nonrenewal
- 0820 Underwriting Delays
- 0822 Policy Audit Dispute
- 0823 Health Status
- 0828 Rescission
- 0834 COBRA
- 0835 Group Conversion
- 0837 MIB Reports
- 0840 Continuation of Benefits
- 0845 State Specific Other - Underwriting
- 0846 Dependent Coverage to Age 26
- 0902 Unfair Discrimination
- 0904 Financial Privacy
- 0905 Misleading Advertising
- 0906 Health Privacy
- 0910 Agent Handling
- 0911 Unauthorized Entity
- 0912 Internet Related
- 0913 Fiduciary Theft
- 0915 Misrepresentation
- 0917 Policy Delivery
- 0918 Misappropriation of Premium
- 0919 Not appointed with Company
- 0921 Deceptive Cold Lead Advertising
- 0922 High Pressure Tactics

- 0923 Duplication of Coverage
- 0926 Misstatement of Application
- 0929 Fraud/Forgery
- 0930 Other Marketing and Sales
- 0933 Failure to Submit Application
- 0934 Premiums Misquoted
- 0935 Other Violation of Insurance Law/Regulation
- 0937 Using an Unlicensed Name
- 0938 Summary of Benefits
- 1001 Adjuster Handling
- 1002 Prompt Pay
- 1003 Willing Provider
- 1004 Participating Provider Availability/Timely Access to Care
- 1005 Unsatisfactory Settlement/Offer
- 1006 Pre-existing Condition
- 1007 Medical Necessity Denial
- 1010 Post Claim Underwriting
- 1012 Subrogation
- 1015 Claim Denial
- 1017 Usual, Customary, Reasonable (UCR) Charges
- 1018 Out of Network Benefits
- 1019 Co-pay, Deductible, and Co-Insurance Issues
- 1020 Coordination of Benefits
- 1021 Authorization Dispute
- 1022 Primary Care Physician Referral
- 1023 Utilization Review
- 1025 Claim Delay
- 1027 Experimental
- 1028 Assignment of Benefits
- 1030 Cost Containment
- 1035 State Specific (Other)
- 1036 Appeal Non-compliance
- 1037 Claim Recoding/Bundling
- 1038 Recoupment
- 1039 Annual Limit
- 1040 Essential Health Benefit
- 1041 External Review
- 1042 Internal Appeal
- 1043 Lifetime Limit
- 1044 Preventive Care
- 1045 Pharmacy Benefits
- 1046 Maternity and Newborn Care
- 1047 Emergency Services
- 1048 Mental Health Parity
- 1049 Maximum Out of Pocket
- 1050 Ambulatory Patient Services
- 1051 Hospitalization
- 1052 Rehabilitative/Habilitative Care
- 1053 Pediatric Care
- 1054 Laboratory Services
- 1101 Closed Network/Provider Discrimination
- 1103 Class Action
- 1105 Premium Notice/Billing

- 1107 Surrender Problem
- 1115 Delays/No Response
- 1117 Information Requested
- 1118 Delivery of Policy
- 1120 Unsatisfactory Refund of Premium
- 1123 Payment Not Credited
- 1125 Coverage Question
- 1126 Access to Care
- 1127 Quality of Care
- 1128 Company/Agent Dispute
- 1129 Abusive Service
- 1130 State Specific (Other)
- 1132 Involuntary Termination by Plan
- 1133 Provider Listing Dispute
- 1134 Delayed Appeal Consideration
- 1135 Delayed Authorization Decision
- 1136 Access to Fee Schedule/Rates
- 1137 Inadequate Reimbursement/Rates
- 1138 Unfair Negotiation
- 1139 Premium Subsidy
- 1140 Wellness Program
- 1141 Essential Community Provider
- 1142 Choice of PCP (Primary Care Provider)
- 1143 Disabled Individuals' Access
- 1144 MLR (Medical Loss Ratio) Rebate
- 1145 Language Access
- 1146 Notice Requirements
- 1147 Continuity of Care
- Billing/Reimbursement Issue
- Denial of Coverage
- Denied Services
- Dis/Enrollment
- Documentation Requests/Disputes
- Eligibility Determination
- Experimental/Investigational Denial
- Medical Records Dispute
- Plan/Staff Attitude and Service
- Provider Attitude and Service
- Reporting Wrongful Loss of Healthcare Coverage
- Scope of Benefits
- Unknown

"Denial of Coverage" was added as a standard collection element for MY 2017, replacing the "Denial of Covered California Coverage" element (which was displayed in the MY 2016 report as "Denial of Coverage").

The following elements were removed from MY 2017 collection (suggested replacements are noted):

- Denial of Covered California Coverage (map to Denial of Coverage)
- 0806 Continuity of Care (map to 1147 Continuity of Care)
- 0808 Pre-existing Condition (map to 1006 Pre-existing Condition)
- 0825 Unfair Discrimination (map to 0902 Unfair Discrimination)
- 1009 Fraud (Map to 0929 Fraud/Forgery)

Starting in MY 2016, “Experimental/Investigational Denial,” “Denied Services,” “Billing/Reimbursement Issue” and “ Scope of Benefits” were added as standard elements to align with reporting entity data preferences.

The following elements were removed from OPA’s MY 2016 accepted options:

- 1096 Access to Fee Schedule/Rates
- 1097 Inadequate Reimbursement/Rates (HCB only – CA code)
- 1098 Unfair Negotiation – Provider Contract
- 1099 Continuity of Care (map to “1147 Continuity of Care”)
- Dental Scope of Benefits
- Denial of Specialty Mental Health Services by Mental Health Plan
- No Response to Filed Grievance/Not Allowed to File/Unhappy with Result
- Plan Subcontractor/Provider Billing/Reimbursement Issue

For OPA’s MY 2016-2018 reports, “1027 Experimental” was combined with and displayed as “Experimental/Investigational Denial” in the statewide section analysis.

Complaint Result (Disposition)

Required field for first complaint reason selection. Up to three selections allowed. Accepted elements:

- 1201 Policy Not in Force
- 1205 Policy Issued/Restored
- 1207 Advised Complainant
- 1208 Compromise Settlement/Resolution
- 1210 Additional Payment
- 1215 Refund
- 1220 Coverage Extended
- 1223 Unable to Assist
- 1225 Claim Reopened
- 1230 Claim Settled
- 1235 No Action Requested/Required
- 1240 Referred to Outside Agency/Dept.
- 1250 Underwriting Practice Resolved
- 1253 Information Furnished/Expanded
- 1255 Delay Resolved
- 1257 Fine Assessed
- 1260 Cancellation Notice Withdrawn
- 1270 Prem Problem Resolved
- 1277 Deductible Refunded
- 1280 Referred to Other Division for Possible Disciplinary Action
- 1287 Rating Problem Resolved
- 1290 Question of Fact/Contract/Provision/Legal Issue
- 1293 Company in Compliance
- 1295 Upheld/Company Position Substantiated
- 1300 No Jurisdiction
- 1303 Recovery
- 1305 Insufficient Information
- 1310 State Specific (Other)
- 1311 Overturned/Company Position Overturned
- 1312 Withdrawn/Complaint Withdrawn
- Consumer Received Requested Service
- Unknown

DMHC reported duplicate case results for the first time in MY 2018 in order to more directly attribute a result (or results) to each reason for its more complex cases that had multiple reasons reviewed. In the prior years, DMHC recorded up to three results for the complaint case as a whole and all reported results were more generally applied to all reasons. For MY 2018, DMHC collected up to three results per reason (up to nine per case) and used a proxy element (representing a common combination of results) to report more than three case results to OPA. OPA re-attributed the proxy results to the appropriate standard elements for the MY 2018 analysis. For MY 2018 trend analysis displays that compared MY 2018 results with MY 2016 and MY 2017 results, OPA accounted for and removed DMHC's MY 2018 duplicated case results.

For MY 2017 collection, the following standard elements were removed (suggested replacements noted):

- 1217 Entered into Arbitration/Mediation (map to 1290 Question of Fact/Contract/Provision/Legal Issue)
- 1227 Cancellation Upheld (map to 1295 Upheld/Company Position Substantiated)
- 1233 Filed Suit/Retained Attorney (map to 1290 Question of Fact/Contract/Provision/Legal Issue)
- 1239 Referral to Another State's Dept. of Insurance (map to 1240 Referred to Outside Agency/Dept.)
- 1285 Question of Fact (map to 1290 Question of Fact/Contract/Provision/Legal Issue)

"1257 Fine" was updated to "1257 Fine Assessed" for OPA's MY 2016 collection. "Consumer Received Requested Service" was first reported by DMHC in MY 2015 and added as a standard element for OPA's MY 2016 collection.

Date Complaint Opened

Required field. Accepted elements: Date in format mm/dd/yyyy that is before or on the date closed and that is on or after the DOB (if one is provided).

Date Complaint Closed

Required field. Accepted elements: Date in format mm/dd/yyyy that is after or on the date opened.

Only complaint records with a close date on or between January 1 and December 31 of the measurement year were accepted for analysis.

Appendix B. Supplemental Survey Data Collection for Measurement Year 2018

The following tables and fields were used to collect data and information about the reporting entity's consumer assistance activities through its service center or centers. For MY 2018, OPA condensed collection fields previously found in Sections II-VI into a single section about Service Center protocols and systems. For most of the updated Section II, reporting entities were instructed to only provide new information if protocols or systems had changed since the prior year survey submission.

Overview Fields

- Department
- Service Center Name
- Public Phone Number - Main Line
- TTY / TDD Line
- Other Public Phone Lines and Target Audience
- Days/Hours Open
- Website of the Service Center

I. Number and types of requests for assistance received

1. Number of Requests for Assistance by Month and Mode of Contact (January 1 – December 31, 2018)

Month	Telephone	Mail	Email	Online	Fax	Counter / In-Person	Other	Unknown	Monthly Total
January									
February									
March									
April									
May									
June									
July									
August									
September									
October									
November									
December									
Total Annual									

2. Telephone Call Overview – Yearly Metrics (January 1 – December 31, 2018)

- Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)
- Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)
- Number of jurisdictional inquiry calls

- Number of non-jurisdictional calls
- Average number of calls received per jurisdictional complaint case (e.g., follow-up calls by the consumer after a complaint is filed, either to relay additional information for the case review or to check status)
- Average wait time to reach a CSR
- Average length of talk time (time between a CSR answering and completing a call)
- Average number of CSRs available to answer calls (during Service Center hours) -- Please indicate Full Time Equivalents (FTEs). You may also indicate staffing variations by season, month, or day of the week, if variable.

3. Top 10 Topics for Non-Jurisdictional Inquiries/Complaints (January 1 – December 31, 2018)

Ranking	Non-Jurisdictional Inquiry/Complaint Topic	Organization(s) that these Inquiries were Typically Referred to	Volume (if ranking is based on data)
1 (most common)			
2			
3			
4			
5			
6			
7			
8			
9			
10			
Indicate if this ranking is based on data or estimated:			

II. Service center's protocols and systems

1. Service Center Organizational Structure and Role

- Please submit the current organization chart(s) for the Service Center with positions and classifications listed.
- In addition, please provide an organization chart displaying the Service Center's position in the Department's overall structure.
- If the Service Center's role or authority changed in 2018, please briefly describe the change and list the associated legislation, regulation, all plan letter, or similar policy.
- Are there any other issues to be noted that could affect 2018 data findings or trending comparisons? (E.g., Service Center staffing reduction, changes to hours, other operations changes, etc.)

2. Service Center Protocols

For this section, please submit document(s) that best demonstrate enterprise-wide protocols currently used by the Service Center. If any written protocols have been added or updated since last year's submission, submit the new document electronically as an attachment (Microsoft Word or PDF preferred). List any new or updated documents by title below, indicate if the document is publicly available, and identify the major elements addressed in each document.

- Document Title
- Indicate if currently publicly available (Yes /No)
- Indicate below which of the following elements are addressed in the document (Yes/No)

- Performance Standards for Complaints (e.g., response times, customer service standards or guidelines, etc.)
- General Protocols and Procedures (e.g., description of the step-by-step process - intake to resolution)
- Language Assistance Protocols and Procedures
- Urgent Case Protocols and Procedures
- After-Hours Protocols and Procedures
- CSR Training
- CSR Tools (Referral guides, phone scripts, etc.)

3. Service Center's Current Phone/Customer Relationship Management/Database Systems

If any Service Center systems have changed or been updated since last year's submission, please complete any relevant fields. Otherwise please note "No Changes" in the first field.

- System Name Used by the Service Center
- Product Name(s) if different than the system name (e.g., proprietary products used in system development)
- Developer Name (internal IT unit and/or contractor)
- Date Established
- Date of Last Significant Upgrade
- New Features/Enhancements/Other Changes (Please Describe)

4. Methodology: Data Collection, Analysis, and Reporting

For this section, please submit any updates to methodology documents currently used by the Service Center staff in an electronic format (in Microsoft Word whenever possible). Methodology documents include those that establish system controls and processes to ensure that data collection and related reporting is standardized and accurate.

- Data Collection -- Submit updated form(s) used by the Service Center to record complaint information (e.g., online complaint form, other intake forms or templates)
- Data Analysis Quality Assurance and Methodology -- Submit new reference documents (e.g., Data dictionary, quality assurance procedures, or other policies for ensuring accurate data; crosswalk mapping data to OPA categories; etc.)
- Have there been any data collection changes for your Service Center that would affect OPA's 2018 data analysis and trending with other Measurement Years?

III. Enrollment / Covered Lives

Please provide 2018 enrollment information for your program and the health plans/insurers your department oversees. Please submit enrollment calculated using the same methodology as last year if possible. Use a separate tab(s) to add chart(s) that includes a lengthy list of health plans/insurers.

For the enrollment dataset(s) submitted, indicate:

- Enrollment month submitted
- Enrollment report date
- Description of dataset (e.g., source, exclusions/inclusions, etc.)
- Same methodology used as last year? (Yes/No) -- If no, please describe the change: